Advanced Bariatric Surgery™

1000 N. Davis Drive, Suite B, Arlington, TX 76012
12222 N. Central Expressway, Suite 250, Dallas, TX 75243
Phone: (817) 342-0232 Fax: (817) 275-1401
www.MyCompleteTransformation.com www.AdvancedCosmeticSurg.com

New Patient Form *Account#:* _____

Patient Name: _____ **DOB:** _____ **Age:** _____

Home Address: _____ **Sex: Male or Female (Please circle)**

City: _____ **State:** _____ **Zip:** _____ **Pharmacy#:** _____

SS#: _____ **Employer:** _____ **Occupation:** _____

Home #: _____ **Work#:** _____ **Cell#:** _____

Email Address: _____

Spouse Information

Spouse's Name: _____ **DOB:** _____ **SS#:** _____

Work/Cell#: _____

How were you referred? _____ **Reason For Visit:** _____

Insurance Information

Insurance Company: _____ **Provider#:** _____

ID# _____ **Group#** _____

Policy Holder Name: _____ **SS#:** _____ **DOB:** _____

Employer: _____

Emergency Contact

Emergency Contact Name: _____ **Relationship:** _____
Phone #: _____ **Phone# 2 :** _____

Please List 2 Phone Numbers

Assignment of Benefits

I authorize the release of any medical information about me to Dr. Clayton A. Frenzel, his assistants or insurance company that is needed in the course of examination or treatments. Benefits to be paid to Advanced Surgery. I understand there is a $500.00 fee to schedule surgery. Payment for office visits is required at the time services are rendered. For all procedures, advanced payment is required two weeks prior to surgery. For all procedures less than $500.00, payment must be at the time of treatment or before.

_____ _____
Patient Signature **Date**

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Patient's Contract For Compliance

I, _____, acknowledge and agree that upon consenting to and undergoing bariatric surgery, I will participate in the following programs, sessions and support groups which are created to promote the success of the bariatric surgery:

1. I will participate in a one-year follow-up program that requires regularly scheduled visits with Dr. Clayton Frenzel at 1 week, 1 month, 3 months, 6 months and 1 year post-operative and yearly visits for 5 year thereafter.

2. I will agree to attend monthly post-operative support group meetings.

3. I will start an aerobic fitness program. In this program I will be performing some type of aerobic exercise for a minimum of 30 minutes per day by the end of the first 30 days.

4. I will follow all dietary guidelines recommended by Dr. Clayton Frenzel and/or a Dietician and will keep a detailed record for the first 6 weeks post-surgery.

5. I will participate in psychotherapy sessions with a licensed psychotherapist if and when deemed necessary for the resolution of any psychological issues that may limit my successful weight loss.

6. I agree that in order for me to achieve the greatest degree of success by this surgery these guidelines established by Dr. Frenzel must be strictly followed.

7. If I have any questions regarding these guidelines, I will discuss them with Dr. Frenzel or his staff before signing this agreement.

8. During my pre-operative evaluation, I was informed about reasonable outcomes and was given a thorough explanation of the risk, benefits and uncertainties of the procedure.

By signing this agreement I acknowledge my complete understanding, agreement and compliance with the stated follow-up program.

_____ _____

Patient Signature ***Date***

_____ _____

Witness ***Date***

Advanced Bariatric Surgery™

Patient Medical History:

Patient: _____ Date: _____

Age: _____ Height: _____ Weight:_____lbs. Sex: ☐ Female ☐ Male

What is the most you have ever weighed?: _____lbs.

KNOWN ALLERGIES: ☐ Latex ☐ Adhesive Tape ☐ Sulfa ☐ Penicillin ☐Aspirin ☐ Codeine

☐ No Known Allergies ☐ Other Medication Allergies: _____

HISTORY OF SPECIFIC MEDICAL PROBLEMS:

☐ HIV
☐CANCER
☐ASTHMA
☐BRONCHITIS
☐EMPHYSEMA
☐COPD
☐SLEEP APNEA
☐ENT PROBLEMS
☐HARD OF HEARING
☐SINUS PROBLEMS
☐HEART MURMUR
☐ARTHRITIS
☐SEIZURES
☐ANEMIA

☐LIVER DISEASE
☐HEPATITIS TYPE___
☐HEART DISEASE
☐CONGESTIVE HEART FAILURE
☐HEART ATTACK #_____
☐HIGH BLOOD PRESSURE
☐STROKE #_____
☐CHEST PAIN
☐PACEMAKER
☐PALPATIONS
☐CATARACT
☐DIABETES
☐THYROID PROBLEMS

☐BLEEDING DISORDER
☐GI PROBLEMS
☐UCLERS
☐ESCESSIVE SCARRING
☐FEVER BLISTERS
☐PROSTATE PROBLEMS
☐KIDNEY/BLADDER/URINARY
☐BACK/NECK PROBLEMS
☐GLAUCOMA
☐RETINA PROBLEMS
☐HIGH CHOLESTEROL
☐DEPRESSION
☐ANEXITY

List any other problems or concerns: _____

Name of previous physician: _____ Last Exam Date: _____

SOCIAL HISTORY:

Do you drink alcohol? ☐Yes ☐No How many drinks per week? _____

Do you smoke? ☐Yes ☐No How many packs per day? _____ When did you quit? _____

SURGICAL HISTORY: (list all prior surgeries and what year)

_____

_____

Complications with anesthesia?: ☐Yes ☐No If yes, what was the complication?

_____

Weight Loss History:

Please check the appropriate boxes and add notes as needed (please be specific).

My obesity started:

[ ] In childhood [ ] At puberty [ ] As an adult [ ] After pregnancy [ ] After a traumatic event.

Please describe:

Height:	Birth Weight:	High School Weight:
Highest Adult Weight:	Lowest Adult Weight:	

How many years at current weight? _____

Most weight lost on any program? _____

Age at which you first seriously dieted? _____

Taste preferences (please check all that apply):

[ ] Sweets [ ] Salty [ ] Fast Food [ ] Comfort Food [ ] Other

Eating Habits (please check all that apply):

[ ] Binge eater [ ] Stress [ ] Boredom [ ] Loneliness [ ] Other

Medically supervised weight loss attempts:

Other supervised weight loss programs:

Diet	Dates	Duration	Max Wt. Loss	MD/ Supervised
Jenny Craig				
Nutri-Systems				
Weight Watchers				
Opti/Medifast				
Fen-Phen/Redux				
Meridia				
Lindora				
T.O.P.S.				
Accupuncture				

Habits:

Are you a smoker? [ ] Yes [ ] No Packs/Day: _____

Have you ever been a smoker? [ ] Yes [ ] No Age started: _____ Age quit: _____

Do you consume Alcohol? [ ] Yes [ ] No Drinks/Day: _____

Do you consume recreational drugs? [ ] Yes [ ] No Type/Frequency: _____

Please describe your exercise routine. Include type of exercises, frequency, and physical limitations:

Please write any other concerns that you have regarding your health or bariatric surgery:

Motivation to get surgery for weight control:

Describe your goals as you achieve weight loss:

Women Only:

Date of last Menstrual Cycle:	Are you cycles regular?
Are you using Birth Control? [ ] Yes [ ] No	If yes, what type:
# of pregnancias:	# of live births:
Miscarriages: Abortions:	

Pregnancy	Year	Weight at start	Weight at delivery
Pregnancy #1			
Pregnancy #2			
Pregnancy #3			
Pregnancy #4			

Problems during or after pregnancy:

Medication History: (please include Vitamins; Herbal Supplements)

Medication	Dosage	Reason	Prescribing Doctor

Please list any medications to which you are ***allergic*** to:

Medication	Reaction

Allergic to ***Latex***? [ ] Yes [ ] No

Allergic to ***Food***? [ ] Yes [ ] No

Please list all previous surgeries and hospitalization stays:

Year	Surgery	Hospitalization Stays

Family History:

Please check which, if any, of your family members had any of the following conditions: (mother, father, sibling, grandparent, aunt/uncle)

Anemia:	Stroke:
Sleep Apnea:	Obesity:
Kidney Disease:	Cancer:
Diabetes:	Gallstones:
Gout:	Heart Disease:
High Blood Pressure:	Blood Clots:
Bleeding Problems:	Obesity Related Issues:

Additional Comments:

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in that situation.

How likely are you to dose off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose, the most appropriate number for each situation:
0 = would never doze **2 = moderate chance of dozing**
1 = slight chance of dozing **3 = high chance of dozing**
It is important that you circle a number (0 to 3) on each of the questions.

SITUATION	CHOICE OF DOZING (0 - 3)
Sitting/Reading	0 1 2 3
Watching Television	0 1 2 3
Sitting Inactive in a public place-For ex: a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch {when you've had no alcohol}	0 1 2 3
In a car while stopped in traffic	0 1 2 3
	TOTAL SCORE:

Scoring your results:
Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you circled in each category to get your total score.

The Epworth Sleepiness Scale Key:
A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness.
A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps:
This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individual identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. This form must be completely filled out.

Patient Name: _____ SSN#_____

Phone Number: _____ D.O.B. _____

Email Address: _____

Medical Provide to Release Records

_____
_____
_____
_____
_____
_____

Medical Provider Receiving Records
Advanced Bariatric Surgery
Dr. Clayton A. Frenzel, P.A.
1000 N. Davis Dr. Ste. B
Arlington, TX 76012
Phone: (817) 243-2032
Fax: (817) 275-1401

Circle specific articles of information (and insert specific dates if applicable)
All Dates Range of Dates_____ Progress Notes Labs Operative Reports
Radiology Reports Correspondence Hospital Records Tests Results Consultations

Section B: Must be completed only if a health plan or health care provider has requested the authorization.

- Will the health plan or health care provider requesting the authorization receive financial or any kind of compensation in exchange for using or disclosing the health information described above? Yes _____ No _____
- I understand that my health care and the payment for my health care will not be affected, if I do not sign this form.
- I understand that I may see and copy the information described on this form if I ask for it, and that I receive a copy of this form after I sign it. *Further,* **I understand there may be a fee for a copy of this information.**

Section C: Must be completed for all authorizations.

- What is the purpose of the use or disclosure?: _____
- I understand that this authorization will expire on ___/___/___. Or at the term of _____ event. If not specified, this release will expire 180 days from the date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.
- I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug and alcohol abuse, mental health treatment, AIDS or any other medical information.

_____ _____
Patient Signature Date

Advanced Bariatric Surgery™

Dr. Clayton A. Frenzel, P.A.

PATIENT CONSENT TO TREATMENT

PURPOSE: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather to make you better informed so that you may give or withhold your consent to the proposed treatment.

CONSENT TO TREATMENT: I voluntarily request Dr. Clayton Frenzel, as my physician, and such associates, assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment with Dr. Clayton Frenzel. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my condition outcome may be affected. During the course of treatment, I may be required to make frequent follow-up visits to review diagnostic test results. Patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associates apprised of any changes in my medical condition. Certain diagnostic test, treatments and drug therapies can be dangerous under certain medical conditions or medication use. Pregnancy is one such medical consideration and females must be certain to acknowledge this condition prior to diagnostic imaging and initiation of any medication therapy. Female patients who become pregnant during the course of their treatment with Dr. Clayton Frenzel will notify their prescribing physician if they are on medication therapy.

Furthermore, I understand that no warranty or guarantee will be made to me as to the result of any medication therapy, treatment or cure of my condition. I have the opportunity to ask questions about my condition and treatment, risks of non-treatment and the medication therapy, medical treatment(s) or diagnostic procedures(s) to be used to treat my condition, and the risks and hazards of such medication therapy, treatment(s) and procedure(s), and I believe I have sufficient information to give this informed consent. I hereby consent to treatment.

_____ _____

Patient Signature *Date*

Dr. Clayton A. Frenzel, P.A.

ACKNOWLEDGEMENT
TO RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, Advanced Bariatric Surgery ("PROVIDER") originates and maintains health records describing my health history, symptoms, examination and tests results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals and as required or permitted by law without my consent.

The PROVIDER'S *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this acknowledgment. I understand that the PROVIDER reserves the right to change the Notice of Privacy Practices.

I have been provided and have reviewed the PROVIDER'S *Notice of Privacy Practices* dated **March 25, 2011.**

_____
Signature of Patient or Legal Representative

_____
Print Name of Patient or Legal Representative

Date: _____

I give permission to Advanced Bariatric Surgery to release my private health information to the following person(s). Please print below.

_____

_____

_____

Advanced Bariatric Surgery™

Dr. Clayton A. Frenzel, P.A.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. Clayton A. Frenzel, P.A. has adopted the following privacy policies:

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the sole purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Advanced Bariatric Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its used for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a used or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of you decision.

Additional Uses of Information

Appointment reminders: Your health information will be sued by our staff to send you appointment reminders by mail or to contact you by phone regarding appointment reminders.

Information about treatments: Your health information may be used to send your information or the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your Protected Health Information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your Protected Health Information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed; and
- The right to receive a printed copy of this notice.

Advanced Bariatric Surgery's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Review Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these provisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy, Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting: **Dr. Clayton A. Frenzel, P.A. , 1000 N. Davis Dr. Ste. B, Arlington, TX 76012 (817) 342-0232.**

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: **Daphne Danns or Tami Holden, 1000 N. Davis Dr. Ste. B, Arlington, TX 76012 (817) 342-0232.**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date:

This notice is effective on or after March 25, 2011.